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BY HAND DELIVERY

June 8, 2005

Commissioner Robert E. Nicolay
Chairman
Certificate of Need Task Force
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Testimony for Public Record

Dear Commissioner Nicolay:

I, and CareFirst, would like to thank the MHCC for appointing me to the CON Task Force. This letter follows your directive that Task Force members submit their statements in writing. I am submitting this on June 8, as I will be out of town from this afternoon through June 13, 2005. I was recommended for the Task Force by CareFirst Blue Cross Blue Shield (CareFirst) and CareFirst supports this letter.

This letter incorporates and supplements my letter to Pam Barclay of September 10, 2004. In that letter, I submitted CareFirst's recommendations regarding the MHCC's procedural regulations governing the Certificate of Need program. That letter is supplemented because the charge of the Task Force is broader than the consideration of the MHCC's procedural regulations, though that letter did address some changes that would be required in the law – a clear part of the Task Force's mandate. CareFirst and I have been actively involved in many hospital CON applications over the years. As a result, much of this letter addresses hospital related topics.

A. Interested Party Status and Notification

The current regulations provide that CareFirst, as a third-party payor, can become an interested party by demonstrating that a substantial increase in overall costs to the health care system would result from approval of a project. (newly numbered COMAR 10.24.01.01B(19)(c)). This regulation is cumbersome. CareFirst is Maryland's largest private sector health insurer and, as such, pays for a substantial share of the admissions and outpatient visits to all Maryland hospitals. Accordingly, rather than have to obtain interested party status on a project-by-project basis, CareFirst asks that it be designated as an Interested Party in all hospital CON applications involving Total Uses of Funds (as reported on the Project Budget form) in excess of \$25,000,000. CareFirst may want to seek interested party status in other CON applications, but is suggesting the \$25,000,000

threshold as one that is high enough to ensure that the impact would be large enough to be of significance to our members.¹

CareFirst should be given interested party status, even if it supports a CON application and does not wish to cite the application as out of compliance with any COMAR regulation (the current requirement for interested party status). Interested Party status will reserve CareFirst's appeal rights and its ability to comment on any conditions that adversely affects its members or any modification – as well as on important MHCC recommended findings such as the quantification of efficiencies.

On a related basis, CareFirst requests that COMAR require that a copy of CON applications that meet the above-stated automatic Interested Party threshold be sent to a CareFirst employee and address that would be designated by CareFirst and maintained by the MHCC.

B. Scope of Services Covered By CON

CareFirst appreciates that the listing of medical services in proposed COMAR 10.24.01.01B(25) reflects services that appear in the Commission's inventory of service capacity. CareFirst believes that the MHCC should increase its focus on outpatient services at acute care hospitals. In the year ending March 2005, such services accounted for 28.4% of charges totaling \$2.67 billion in hospital charges. Further, the 11.24% increase in outpatient charges from the prior twelve months was well more than the 9.15% increase in inpatient charges. (HSCRC, *Monitoring Maryland Performance*, June 2005) The MHCC might begin by adding emergency room services to its list of medical services and by developing a state plan chapter devoted to such services. This effort might be followed by a focus on other non-inpatient bed-related hospital services.

At the same time, CareFirst recommends that the MHCC remove such inpatient services as obstetrics from its list. Unlike ER services and other service areas (e.g., ambulatory surgery), where additional capacity may lead to additional utilization, there is no reason to believe that additional inpatient OB bed capacity will result in additional use.² An alternative to removing Obstetrics from the list, while maintaining an interest in the quality and efficiency of obstetrics services, might be to only require a CON for OB at hospitals with less than 100 licensed acute beds or an average daily census (ADC) of less than 70.

Further, the work out of Dartmouth led by Dr. Wennberg, suggests a capacity/volume relationship between cardiac cath labs and cardiac treatments, but not between open heart surgery units and cardiac treatments. This suggests that, perhaps, the MHCC might want to consider whether it should request authority over cardiac catheterization labs.

¹ As a former teacher of Government Regulation, I cannot stress enough the potential value of giving payers a prominent role in regulatory proceedings. Staff, alone, should not be relied upon to provide balance to the inherently unbalanced input from the provider seeking approval.

² CareFirst notes that of the 37 states that have a CON program, only 17 require a CON for OB services. 2004 Relative Scope and Review Thresholds: CON Regulated by State; www.ahpanet.org; 9/10/04.

CareFirst believes that hospice and home health services could be removed from the list of services to be reviewed with little or no harm to the public.³ Some of the staff and other resources now being devoted to review of obstetrics and these services could be freed up to address other issues.

CareFirst supports the exemption of business type equipment and would broaden that exemption – or interpret it more broadly – to include computer type systems such as IT systems and CPOE systems. Such systems should be up to hospitals to install without the need of a CON and without any special capital related rate increase. If the HSCRC wishes to develop a Pay for Performance rate adjustment that encourages such capital development (the MHCC might want to recommend such an adjustment), that would be appropriate, but payers should not be paying twice for such investment.

CareFirst supports an increase in the threshold for review. We believe the appropriate threshold for hospital renovation projects is in the range of \$5 – 10,000,000. It is not clear that an inflator need be applied given the large increase from \$1,600,000. Further, CareFirst notes that the operating cost associated with \$10,000,000 in capital cost is a tiny portion of a hospital budget and, without a CON, should not lead to higher payment rates. CareFirst does not take a position on the appropriate threshold for other services, other than to note that there is no reason why the threshold need be the same for other types of projects.

C. Coverage

In regard to COMAR 10.24.01.02A(3)(b)(i), CareFirst believes that excess capacity adds unnecessary cost to the health care system. Therefore, CareFirst believes a project that does not increase the total licensed bed capacity of a hospital, but which includes excess capacity, should require a CON. CareFirst is concerned that the current methodology may foster excess capacity by allowing hospitals to replace excess capacity if they do not change the number of beds. This problem is exacerbated by the 140% rule but also applies to services, such as rehabilitation, that are not subject to the 140% rule. The “least costly alternative” should be a key criterion in every CON proceeding and the elimination of all excess capacity should be applied to that criterion, even if the number of beds is being reduced, but to a level above that needed.

D. 140% Rule/Need methodology

CareFirst strongly urges the MHCC to seek the elimination or modification of the 140% rule. The 140% rule served its purpose of eliminating paper beds. Now it sometimes creates paper beds, by giving a hospital more licensed beds than its physical capacity. Most importantly, the 140% rule creates a license for more beds than are needed. The 140% rule means that hospitals’ expected occupancy, for licensing

³ CareFirst believes that adding capacity for hospice services neither increases hospice rates nor generates inappropriate hospice use and that home health agencies have negligible capital costs which cannot create excess capacity.

purposes, is 71.4% ($100/140 = .714$). In most jurisdictions, this is much too low an occupancy rate for need purposes – and is well below the need methodology in the SHP.

Either the 140% rule should be eliminated, or it should be amended to reflect appropriate target occupancy rates.

CareFirst believes the current MSGA need methodology yields approval of too many hospital beds. CareFirst supports the current movement toward private rooms. However, private rooms are associated with higher achievable occupancy rates and lower lengths of stay – through lower infection rates, fewer transfers, etc. Currently, CareFirst's 3,300,000 enrollees are being asked to pay the added capital costs associated with private rooms without realizing the savings available from the higher occupancy rates associated with the efficient use of private beds.

The MHCC should change its need methodology to reflect the higher occupancy rates and lower lengths of stay that are appropriately associated with private rooms. The MHCC should support the elimination of the 140% rule and its replacement with occupancy rates that reflect efficient use of bed capacity. The need standards could vary based upon whether a hospital has, essentially, all private beds in its Medical/Surgical/ Gynecologic/ Addictions (MSGA) service. For example, the current standards for MSGA services are as follows (SHP for Acute Facilities and Services, p. 87)

MSGA Jurisdictional Minimum Occupancy

<u>Average Daily Census (Projected)</u>	<u>Minimum % Occupancy</u>
0-49	70
50-99	75
100-299	80
300+	83

CareFirst recommends adjustments such as the following:

MSGA Jurisdictional Minimum Occupancy

<u>Average Daily Census (Projected)</u>	<u>Minimum % Occupancy</u>
0-50	70/75 ^a
50-100	75/80
100-300	80/85
300-750	83/87
750 +	85/88

^a The higher of the two occupancy rates applies to private beds and the lower one applies to all others.

In developing a revised MSGA need methodology, the MHCC should consider the voluminous and important work done by the Dartmouth Group, led by Dr. Wennberg. That research has shown that higher population based use rates are not associated with better outcomes or quality but, if anything, the opposite relation exists. The conclusion

CareFirst draws is that, for low use rate jurisdictions, the need methodology should not be based upon statewide average age adjusted use rates and average casemix adjusted lengths-of-stay. Jurisdictions with below average use rates should be projected to maintain such below average use rates while jurisdictions with above average use rates should be projected to bring those down toward the average.

In developing other types of standards, the MHCC should rely less on the proposals of “interested expert groups”. More reliance should be placed on affordability and cost effectiveness. Imagine if our schools were developed according to standards proposed by the Classroom Teachers Association or some Association of Grade School Architects. Some people might well like that, but taxpayers, who foot the bill, would not accept the consequences. Hospital standards are, too often, accepted without consideration of the financial consequences.

In developing standards, the MHCC should consider the dynamic implications of its standard and attempt to encourage reasonable efficiency. An example is a standard based upon the average number of visits per Emergency Department treatment bay. This standard has a tendency to decline over time for two reasons 1) hospitals with “too few” bays find it easy to increase, while hospitals with “too many” bays stand pat; and 2) bays are built according to future projections of use which are almost always more than current use – therefore reducing the current ratio of visits to bays. Instead the MHCC should use a standard such as the 30th percentile – whereby 30% of hospitals show they can provide that number of visits per bay. Naturally, special consideration should be given to hospitals that train significant numbers of residents in their emergency rooms or that have special needs, but the current averaging system encourages growth – in an expensive service for which the MHCC should be encouraging alternatives.

E. Scope of Regulations

CareFirst believes that many of the regulations are unnecessary. Some represent overly intrusive investigation of hospital management decisions and some relate to universally met criteria. CareFirst believes that need, access, cost, viability, and least costly alternatives are most important. The MHCC should consider eliminating the need to address utilization review and control programs, the charity care policy, transfer and referral agreements, interpreters, in-service education, overnight accommodations, required social services, and the submission of letters of support. The MHCC should consider broader constraints such as an all-inclusive constraint on dollars per bed (which could vary by service) – while continuing the policy that explained dollars over the threshold be financed by the hospital. Some similar outpatient constraint might be developed. The broad constraints could replace the narrower constraints such as Departmental Gross Square Feet (DGSF) per bed and the Marshall Valuation Service cost per square foot.

CareFirst generally supports the idea that hospitals should have more freedom on projects financed without a rate increase than on projects for which they seek (or reserve the right to seek) an associated rate increase (another reason to not base standards on

averages). We encourage standards that encourage use of the pledge. If the MHCC continues to use the DGSF/MVS limits, then the cost above the limit that hospitals must absorb should be fully developed cost. The cost per square foot should be before the MVS comparability adjusters are removed, those are still costs, they just don't relate to the MVS standard. Further, in addition to the full construction costs, the hospital should have to absorb the allocated share of inflation, contingencies, financing/interest costs, etc. The current DGSF/MVS analysis always generates a very small rate offset. While fully loading the cost will help, a broader, all-encompassing dollar standard, within which hospitals have much more freedom to design their physical plant, is preferable.

F. Exemption

In regard to COMAR 24.01.04A(6), CareFirst is not generally supportive of the need for a CON to close either a hospital or a service, so CareFirst asks that the proposed amended regulation be further amended to read in relevant part as follows: (6) The closure of an acute general hospital or part of a hospital, in a jurisdiction with fewer than [three] two acute general hospitals.

G. Procedure for Review

Re: 10.24.01.08B – Submission[s] of Applications. As discussed above, CareFirst recommends that “Submissions” remain plural and that, for hospital projects including total capital costs above a threshold (e.g., \$25,000,000 in Total Uses of Funds), a copy should be submitted to a designated name and address of a CareFirst employee.

CareFirst also believes that it would be appropriate for interested parties to have the opportunity to submit completeness questions for the staff's consideration during staff's review of applications for completeness. CareFirst has noticed that some CON applications are docketed as complete, even though applicants have not provided some mandated information. Examples of such defects include the failure of applicants to detail the cost elements that COMAR requires to be specified or not listing (or listing incompletely) the assumptions underlying tables for which COMAR requires assumptions to be listed. Moreover, the results of calculations are often presented without the accompanying underlying calculations being offered. These practices are confusing and impede review by staff and interested parties.

CON applications are submitted in hard copy form and are compiled using various software programs that may not be available to all parties. In addition, the CON applications are a compilation of text, spreadsheets and graphics that must be assembled in electronic form. CareFirst suggests that all applicants be required to submit electronic copies of their complete CON applications in the “.pdf” file format established by Adobe Acrobat. This form of file sharing is widely used (e.g., by the federal government for posting of regulations) and would make the material electronically accessible to the staff and all interested parties.

Finally, CareFirst recommends that the MHCC create a directory for each CON application on its web site and have all correspondence regarding that CON be posted in pdf format. This would greatly enhance the ability of interested parties to meet the time frames imposed upon them.

H. Commission Decision and Action on Applications

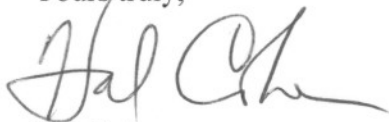
CareFirst has given considerable thought to this issue. On balance, CareFirst asks that these regulations be changed so that, at least in cases involving competing applicants, staff should be designated as a separate interested party and should be required to issue a staff recommendation that the parties can address prior to the presentation of the reviewer's draft recommendation. CareFirst also suggests that if some, but not all, staff is assigned to the Commission, the staff not assigned to the Commission be excluded from the ex parte communication rules. This process will allow the applicant and interested parties the opportunity to discuss the CON applications with staff and receive clarification in the needed timeframes.

I. Evidentiary Hearings

CareFirst suggests the following: "10.24.01.11H Participation of Staff. The staff of the Commission shall issue a written recommendation as to the designated genuine issues, and shall be subject to cross-examination on the written recommendation." The MHCC only holds hearings during important, heavily contested cases. CareFirst believes requiring staff to present and defend its position at these hearings would sharpen the conceptual foundation of decisions and significantly enhance due process.

Again, thank you very much for the opportunity to review and comment on these important matters. I look forward receiving the written testimony, reviewing staff's recommendations, and participating in future Task Force meetings. I will not be available for the July 14 meeting, as I will be in Paris on Bastille Day.

Yours truly,



Hal Cohen
Consultant

Cc: John Picciotto
Greg Vasas
Jack Keane